Northern Lights Special Education Cooperative
www.nlsec.org

16 East Hwy 61; PO Box 40 ~ Esko, MN 55733
Phone (218) 655-5018 ~ Fax (218) 451-4511

PARENT PERMISSION FOR AUDIOLOGICAL ASSESSMENT

DATE:_____

I give the Northern Lights Special Education Cooperative Audiologist permission to assess, observe, or make audiological recommendations for my child,

_____
Student's Name

If you would like us to share the results of your child's evaluation with your clinical audiologist or physician, please write the name of the clinic or organization and their address in the space below:

Name: _____ Telephone:_____

Address:_____

Name: _____ Telephone:_____

Parent Signature:_____

_____
(Address)

_____

_____
(Telephone)